HOLICKI EYE CENTERS

Diseases & Surgery of the Eye
Joseph P. Holicki, D.O.
Board Certified Ophthalmologist

PATIENT FINANCIAL POLICIES

Tha***nk you for choosing Holicki Eye Centers for your medical care.***

We are committed to providing our patients with the highest level of service and quality of care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial responsibility rests with the patient**.**

Billing / Insurance Information
Our practice participates with many Medical and Vision plans. If your plan does not cover services provided by our doctors, payment is expected at the time of your visit. We accept cash, checks, Visa, MasterCard, American Express and Discover. There is $35.00 service charge for returned checks. Financing options are available through Care Credit. We appreciate prompt payment, in full, for any outstanding balance. Payments can be mailed in, called in with a credit card or be made online thru our website portal.
You must provide your insurance information and a copy of your ID card(s) at each visit. Without these, we will be happy to see you but payment in full will be due at the time of service. You must bring in your insurance card for the claim to be filed. Once payment is received from the insurance company, we will gladly refund your payment less any co-pays or deductibles. Payment of your required co-pay and any non-covered services are required at the time of service. We may also request payment for deductibles and co-insurance if provided by your insurance at the time of service.
Currently all insurance plans we are contracted with require that we provide the patients full name, date of birth, social security number and complete home address. If you are uncomfortable providing us with this information, we will provide you with a bill so you can file your own claim with your insurance plan and payment in full will be due at the time of service. By signing this form, you are authorizing us to bill your insurance for services provided, authorizing payment directly to the Provider and for release of your information to your insurance carrier. If you do not wish to have your insurance carrier billed for services provided, please submit this request in writing prior to your visit.

Managed Care Insurance and Medicaid Plans
If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance. In most cases, we can help facilitate a referral request but require at least 72 hours in advance of your appointment. If you do not present with a referral for your visit and we cannot obtain one, you can still be seen. However, you accept responsibility for payment prior to services being provided.

Out-of-Network Care / Self-Pay Patients
Payment for medical services is required prior to services being rendered. We accept cash, check, MasterCard, Visa, Discover and American Express. Financing options are available through Care Credit.

Your Rights and Protections Against Surprise Medical Bills
When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's co-payment, co-insurance and / or deductible. Health care providers are required to inform individuals who are not enrolled in a group health plan, or group or individual health insurance coverage, or a federal health care program or a Federal Health Benefits Program, or those not seeking to file a claim with their health plan, or other insurance coverage, in writing (and may also provide it orally, if an uninsured (or self-pay) individual requests a good faith estimate in a method other than paper or electronically), of their ability, upon request or at the time of scheduling health care services, to receive a "Good Faith Estimate" of expected charges.

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Minors / Dependents
All minors are required to be accompanied by an adult 18 years or older. For all services rendered to minors / dependents, we will look to the adult accompanying the patient and/or the parent or guardian with whom the minor/dependent resides for payment. If the accompanying adult is not the subscriber due to separation/divorce, all required information must be presented including insurance cards as well as permission to bill the insurance by the subscriber.

Refractions
Most insurances, including Medicare, do not pay for refractions. A refraction is the measurement taken to determine if there is a need for glasses and if so, your glasses prescription. Payment for the eyeglass prescription is due at the time of service and a valid prescription will not be dispensed until paid for. Patients requesting contact lenses require additional fitting services which are also not billable to medical insurance and these fees are also due at the time of service.

Surgery Fees
If you are having surgery, we will assist you in getting pre-certification or prior approval for your procedure. Most insurances have co-payments, deductibles or both which are associated with surgery. You will be responsible to pay the patient responsibility portion prior to your surgery date. Financing options are available through Care Credit.

Cosmetic / Elective Surgery
Fees for cosmetic surgery not covered by insurance and must be paid in advance of your scheduled surgery date.

Outstanding Balances / Collections / Bad Debt
When a patients account is greater than 90 days past-due and no payment arrangement has been made it will be turned over to our collection company. You may not schedule any future appointments until your balance is paid in full. When a balance remains unpaid, the process of patient discharge will follow.
Patients that have had their balances written off as bad debt due to non-payment, must pay for all future appointments at time of service. We will collect all co-pays or full amount if self-pay prior to the patient being seen in the future.

Financial Hardship
Sometimes proper medical care may seem out of reach due to special financial difficulties or circumstances. To determine eligibility for a financial hardship discount, a Financial Hardship Form must be completed and approved. Services may be discounted or no-charged if approved. This Financial Hardship Form is only valid for 1 year . Our office reserves the right to re-evaluate at anytime throughout the year. If income or financial status changes, we require that the patient report this to the billing department.

No-Shows / Missed Appointments / Late for Appointment
We require that you give our office 24-hour notice when cancelling or rescheduling an appointment. Failure to call us will result in a No-Show on your account. We allow one (1) No-Show for each patient and no fee will be charged. However, each additional "No-Call No-Show" appointment will be assessed a $50.00 fee. This fee is not covered by or charged to your insurance. This fee needs to be paid before being seen at the next scheduled appointment.

Patient Responsibilities / Administrative Services
Letter and Form Completion requiring the doctors review and signature are subject to a $25.00 fee.
Any testing needed to complete a patient's form will be charged to patient and is payable at the time of service.

Please contact our billing department to assist you with any questions.
(517) 279-7927 Monday - Friday 8:00am - 5:00 pm

ANGOLA OFFICE
1202 N. Wayne St.
Angola, In 46703
Ph: (260) 665-5015

COLDWATER OFFICE
142 E. Chicago Rd., Suite A
Coldwater, MI 49036
Ph: (517) 279-7927 | Fax: (517) 278-3393
Optical Ph: (517) 279-6335
www.holickieyecenters.com

STURGIS OFFICE
1409 S. Lakeview Ave.
Sturgis, MI 49091
Ph: (269) 659-4545

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PATIENT FINANCIAL POLICIES

I have read, understand and agree to comply with the terms of the Patient Financial Policies of Holicki Eye Centers and Optical. I have been given a copy of the policies to keep with my records.

This signed form will remain in effect unless rescinded in writing by the patient.

_____
Patient/Guardian Printed Name

_____ _____
Patient / Guardian Signature Date

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